

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008428
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2008

FILED FEB 28 1963

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN **St. Louis**

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY

c. CITY OR TOWN **St. Louis**

Inside Limits
Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION **Homer G. Phillips Hospital**

Inside Limits
Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)
4342 W. Aldine

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED
(Type or print)

First
Willie

Middle
Mae

Last
Carter

4. DATE OF DEATH

Month
2

Day
21

Year
63

5. SEX
Female

6. COLOR OR RACE
Colored

7. Married ☐ Never Married ☐
Widowed ☐ Divorced ☒

8. DATE OF BIRTH
2-13-1916

9. AGE (last birthday)
47

IF UNDER 1 YEAR
Months **0** Days **8** Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Presser

10b. KIND OF BUSINESS OR INDUSTRY
None

11. BIRTHPLACE (City and state or country)
Arkansas

12. CITIZEN OF WHAT COUNTRY
USA

13a. FATHER'S NAME

Lee Carter

13b. MOTHER'S MAIDEN NAME

Mae June Jackson

14. NAME OF HUSBAND OR WIFE

Divorced

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Lonzie Rose

4329 W. Aldine Avenue

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

My parturient Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 hrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month; Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **1/21 18/63** to **2/21/63** and last saw her alive on **1/21/63**. Death occurred at **10** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

2-23-63

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

Pine Bluff, Arkansas

24. FUNERAL DIRECTOR

ADDRESS

Ellis Funeral Home, Inc. 2820 Stoddard St.

25. DATE RECD. BY LOCAL REG.

FEB 23 1963

26. REGISTRAR'S SIGNATURE

Paul Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Frederick E. Culkin

Licensed Embalmer No.

4198

P. O. Address

13th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.